
The Health of Homeless Women: Information for State Maternal and Child Health Programs

The Maternal and Child Health Services Block Grant program (Title V of the Social Security Act) provides leadership to both the public and private sector to build the infrastructure for health care strategies addressing the needs of all mothers and children in the Nation, particularly low-income and other vulnerable isolated populations with limited access to health care. One population for which it is particularly challenging to provide health care is homeless women. The number of homeless women and families continues to increase, and the importance of developing strategies to reach these women (and children) becomes even more critical.

Most state governments first became involved in activities for the homeless primarily as the result of fiscal incentives and planning requirements of the 1987 Stewart B. McKinney Act,¹ which focuses on emergency measures as opposed to the causes of homelessness.² Funding for these and related programs varies from year to year dependent on the type of program, and the political will. Table 1 outlines selected policies and programs for homeless persons. Since 1987, many federal and state agencies have become involved in providing and/or ensuring these services. State Maternal and Child Health (MCH) programs can contribute their skill, knowledge, and networks and take an active role in addressing the health of homeless women. The vulnerability of this population suggests the importance of homeless women as a priority population for public health efforts and programs.³

Characteristics of the Population of Homeless Women

Determining the number of homeless women, whether on a national, state or local level, involves crude, often inaccurate, estimates. The 1990 Shelter and Street Census Count (S-Night, March 20-21) has been criticized as under-counting the homeless population, both in shelters and on the street. Most local estimates of homelessness are higher than the Census count. In an effort to improve the count accuracy, the 2000 Census has made specific plans to partner with local governments, community-based organizations, advocacy organizations, public and volunteer organizations in order to locate "people without conventional housing." Deemed "service-based enumeration," following advance visits with relevant personnel, the count will take place at shelters, soup kitchens, regularly scheduled mobile food vans, and target nonsheltered outdoor locations between March 27 and March 29, 2000.

Estimates of the size of the homeless population can be measured using point-prevalence estimates (e.g., a one-day time period), or by identifying those who come into contact with public or private assistance programs. When counting the homeless, it is important to recognize the difference between

acute versus chronic homelessness, and to include the rural homeless as well as those in urban areas, where the homeless tend to congregate in order to obtain social services. Further, it is also important to recognize the numbers of those at-risk for becoming homeless: families who live doubled-up with relatives or friends, or in their cars, who have low incomes and small to non-existent savings.

Given these caveats, estimates of the number of homeless women and/or families are available in each state's respective *Consolidated Plan*, prepared every five years for the U.S. Department of Housing and Urban Development. The most recent plans were prepared for 1995; new consolidated plans will be released in 2000. MCH programs can access the information for their state at <http://www.hud.gov/states.html>.

Notwithstanding the significant challenges of enumerating the homeless population, we do know that the prevalence of women and families among those who are homeless has increased nationally. According to a survey by the U.S. Conference of Mayors, 37 percent of homeless people in 1999 were families with children, and 13 percent were single women.⁴ Thirty-two percent of all homeless clients according to one survey⁵ are female, and among homeless families, 84 percent are females. Families with children (about 90 percent of which are female-headed⁶) constitute approximately 40 percent of the total homeless population.⁷ Another study states that homeless women comprise one fifth of the U.S. homeless adult population.⁸ Research indicates that families, single mothers, and children make up the largest group of people who are homeless in rural areas.⁹

Table 1. Selected Legislation and Programs Relevant for Homeless Persons

❖	Stewart B. McKinney Act, 1987, (introduced as the Urgent Relief for the Homeless Act). Four amendments made in 1988, 1990, 1992 and 1994. McKinney Homeless Assistance Programs, and Continuum of Care, Department of Housing and Urban Development (HUD)
❖	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Food and Nutrition Service (FNS), Department of Agriculture (USDA)
❖	Food Stamps, FNS, USDA
❖	Medicaid, Health Care Financing Administration (HCFA) and States' Medicaid Programs
❖	States' Children's Health Insurance Programs, HCFA
❖	Health Care for the Homeless (HCH), Bureau of Primary Health Care, Health Resources and Services Administration
❖	Projects for Assistance in Transition from Homelessness (PATH), Center for Mental Health Services, Substance Abuse and Mental Health Administration (SAMHSA)
❖	Access to Community Care and Effective Services and Supports (ACCESS), Mental Health Knowledge Development and Application (KDA), Division of Knowledge Development and Systems Change, SAMHSA
❖	Substance Abuse KDA, SAMHSA
❖	The Community Services Block Grant (CSBG), Administration for Children and Families (ACF): Provides supportive services to homeless individuals and families in local, communities.
❖	Transitional Living Program for Homeless Youth, Family and Youth Services Bureau (FYSB), ACF
❖	Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth, FYSB, ACF: Grants to non-profits for street-based outreach and education.
❖	Runaway and Homeless Youth / Basic Centers, FYSB, ACF: Drug Abuse Prevention program previously included, but unfunded since FY 1996.
❖	Special Projects of National Significance, (Homeless-specific Ryan White AIDS grants only), HIV/AIDS Bureau, Health Resources and Services Administration: Includes HHS/HUD collaborative grants, and evaluation funding.
❖	Administration on Children, Youth and Families (ACYF): Tracks families leaving welfare (and possibly becoming homeless).
❖	Head Start for the Homeless, ACYF: FY 97 and 98 funds are blended with the Head Start program, but still target homeless children.
❖	Battered Women's Shelters, ACF, CDC, and SAMHSA: Funded through Family Violence Prevention and Services/Battered Women's Shelter grants, under the Violence Against Women Act within the 1994 Crime Bill.
❖	Homeless Services Research, National Institutes of Health

As noted above, women at-risk for homelessness and those who actually become homeless have similar social and financial situations. Most women in a sample of 409 women receiving Aid to Families with Dependent Children (women considered to be potentially at-risk for homelessness) did not report having the advantage of family and friends who could provide economic or social support when times were rough.¹⁰ One of the major differences, however, is that women who remain housed have a stronger support network. Moreover, many homeless women who escape violent relationships are bereft of social supports such as family.¹¹

Obviously a woman's income and assets also affect her likelihood of becoming homeless. The work history of 436 sheltered homeless women and low-income women were analyzed by Brooks and Buckner (1996), and 75 percent of the working women in their study were employed in service and sales industries, compared with 61 percent of all women in the nation. Service occupations are mostly part-time and offer lower earnings, little advancement, limited benefits, and are of short duration (around 1.8 years).¹²

Principal Health Issues

Seeking attention for health care becomes a low priority for women who do not know where they or their children will sleep that night, or where they will find their next meal. In one study, after controlling for potential confounding factors, homeless mothers had more frequent emergency department visits in the past year and were significantly more likely to be hospitalized in the past year compared with housed mothers.¹³ Thus, it is even more important to be aware of the health conditions that homeless women face in order to help these women be healthy. These issues are summarized in Table 2.

Health issues of particular importance to women include family planning, pregnancy, female genitourinary problems, and sexually transmitted diseases that are more commonly seen in women than in men. Risks for pregnancy complications due to lack of prenatal care, poor nutrition, stress, and exposure to violence are higher among homeless women.¹⁴ Homeless women may have little choice as to the timing and circumstances surrounding conception, and will become pregnant due to victimization, economic survival, lack of access to contraceptives, uncertain fertility, and desire for intimacy.¹⁵ Homeless women are in great need for family planning services, which could be combined with vocational, social service, and drug treatment programs.¹⁶ Yet, few family planning agencies have special programs for homeless women.¹⁷

About one third of medical problems treated at Health Care for the Homeless locations are chronic physical conditions. The most common (excluding substance abuse) are hypertension, gastrointestinal problems, neurological disorders, arthritis and other musculoskeletal disorders, chronic obstructive pulmonary disease, and peripheral vascular disease.¹⁴ More research is needed on how homeless women with chronic diseases receive treatment.

Common illnesses (such as colds or the flu) that are easily treated in the general population often escalate to more severe problems in the homeless population,¹⁸ and chronic health problems common among the housed population are made much worse by the stress and exposure of homelessness, as well as lack of access to ongoing treatment.¹⁴ A condition as serious as tuberculosis may not be reported until the condition worsens due to limited access to screening and treatment services. In a study of homeless persons seeking medical treatment at a free medical clinic in a small Florida community, the 73.8 percent of those seeking services reported that they were suffering from a recurrence of a health problem that they had experienced within the past year and for which 58.3 percent previously had received treatment.¹⁸

Other health issues, such as stress and nutrition, affect the lives of homeless women more negatively than their housed counterparts. Compared to other low-income women, homeless women seem to be worse off in terms of their emotional and physical welfare. Homeless mothers are more likely to report higher stress levels, avoidant behavior, and anti-cognitive coping strategies.¹⁹ Although they are more likely to have less food to eat,⁵ homeless women and their dependents are more likely to consume higher than desirable amounts of

fat.²⁰ This may be because the most affordable food is often the most unhealthy. Low nutrient intake may have several harmful health effects such as increased risk for chronic disease and compromised growth and development for children.²⁰ The homeless are twelve times more likely than individuals in stable housing to have dental problems. Persons living in unstable housing, such as a hotel or the residence of a friend or relative, are six times more likely to have dental problems.²¹

Perhaps the most troubling health issues for homeless women relate to violence, substance abuse, and mental health (specifically depression). In general, poor women are at a higher risk for violence as poverty increases stress and lowers a person's ability to take control of their own environment and seek protective care.²² In a study of 436 sheltered homeless and low-income housed mothers, it was found that 84 percent of all of these women had at some point been severely assaulted, 63 percent had been assaulted by parental caretakers, 40 percent had been sexually molested as children, 60 percent had been attacked physically by intimate male partners, and 33 percent had been assaulted by their current or most recent male partner.²² Additional studies among homeless women confirm this high prevalence of violence, specifically high lifetime rates of childhood physical and sexual abuse, as well as assault by intimate male partners.²³ Further, violence in the lives of these women serves as a barrier to employment. The social consequences include job loss, loss of job productivity, and social isolation that reinforce the pattern of violence.²⁴

It has been suggested that homeless people may use drugs or alcohol to self-medicate mental illnesses. These conditions may be alleviated, and even momentarily forgotten to a degree, by using marijuana or alcohol. Lack of appropriate health care and stressful living conditions may lead to increased substance abuse. Homeless women comprise a subpopulation at-risk for substance abuse with rates of disorder ranging from 16 to 67 percent. Unfortunately, there exists an imbalance between the need for substance abuse treatment and access to these services. Homeless, substance-abusing women face severe barriers to care,²⁵ and more research is needed to understand the barriers to treatment that are specific to this population.

Table 2. Summary of study findings related to health problems faced by homeless women.

HEALTH ISSUE	KEY FINDINGS
Chronic Disease	<ul style="list-style-type: none"> ◆ The most common chronic physical conditions (excluding substance abuse) are hypertension, gastrointestinal problems, neurological disorders, arthritis and other musculoskeletal disorders, chronic obstructive pulmonary disease, and peripheral vascular disease.¹⁴
Infectious Disease	<ul style="list-style-type: none"> ◆ The most common infectious diseases reported were chest infection, cold, cough, and bronchitis; reporting was the same for those formerly homeless, currently homeless, and other service users.⁵ ◆ Homeless patients with tuberculosis were more likely to present with a more progressed form than non-homeless. ◆ Widespread screening for TB in shelters may miss most homeless persons because many do not live in the shelters, and instead present in emergency departments.³³
STDs/ HIV/AIDS	<ul style="list-style-type: none"> ◆ A mobile women's health unit in Chicago reported that of 104 female homeless clients, 30% had abnormal Pap smears--14% with atypia and 10% with inflammation; the incidence of chlamydia was 3%, gonorrhea 6%, and trichomoniasis 26%.³⁴ ◆ HIV infection was found to be 2.35 times more prevalent in homeless, drug-abusing women than homeless, drug-abusing men.³
Stress	<ul style="list-style-type: none"> ◆ Homeless mothers reported higher levels of stress, depression, and avoidant and anti-cognitive coping strategies than low-income, housed mothers.¹⁹
Nutrition	<ul style="list-style-type: none"> ◆ Currently and formerly homeless clients are more likely to report not getting enough to eat (28% and 25%) than among all U.S. households (4%) and among poor households (12%).⁵ ◆ Contrary to their opinion, homeless women and their dependents were consuming less than 50% of the 1989 RDA for iron, magnesium, zinc, folic acid, and calcium.²⁰ ◆ Subjects of all ages were consuming higher than desirable quantities of fats.²⁰ ◆ The health risk factors of iron deficiency anemia, obesity, and hypercholesterolemia were prevalent.²⁰
Smoking	<ul style="list-style-type: none"> ◆ More than half of both homeless mothers and low-income, housed mothers were current smokers, compared to 22.6% of female adults 18 years and over.¹³
Violence	<ul style="list-style-type: none"> ◆ Poor women are at higher risk for violence than women overall; poverty increases stress and lowers the ability to cope with the environment and live safely.²² ◆ In a study of 436 sheltered homeless and poor housed women: 84% of these women (average age = 27) had been severely assaulted at some point in their lives; 63% had been severely assaulted by parental caretakers while growing up; 40% had been sexually molested at least once before reaching adulthood; 60% had experienced severe physical attacks by a male intimate partner; and 33% had been assaulted by their current or most recent partner.²² ◆ Studies of homeless women reveal high lifetime rates of childhood physical and sexual abuse and of assault by intimate male partners.²³ ◆ A study of fifty-three women homeless for at least three months in the past year demonstrated that this group is at a very high risk of battery and rape, with 91% exposed to battery and 56% exposed to rape.³⁵
Substance Abuse	<ul style="list-style-type: none"> ◆ Homeless women comprise a subpopulation at high risk for substance abuse; rates of substance use disorder range from 16% to 67%. There exists an imbalance between treatment need and treatment access, which suggests that homeless, substance-abusing women are facing severe barriers to care.²⁵ ◆ Some homeless people with mental disorders may use drugs or alcohol to self-medicate.³⁶
Mental Health/ Depression	<ul style="list-style-type: none"> ◆ A case-control study of 100 homeless women with schizophrenia and 100 non-homeless women with schizophrenia found that homeless women had higher rates of a concurrent diagnosis of alcohol abuse, drug abuse, antisocial personality disorder, and also had less adequate family support.³⁷ ◆ Many homeless women with serious mental illness are not receiving care; this is due to lack of perception of a mental health problem and lack of services designed to meet the needs of homeless women.⁸

Studies show that lifetime rates of post-traumatic stress disorder (PTSD), major depression, and substance abuse disorders are overrepresented among homeless women when compared to the rates found in the National Comorbidity Survey.²⁶ Despite this, a cross-sectional study of mothers and their children living in homeless shelters showed that homeless mothers have a high level of unmet need for mental health services.²⁷ A similar study showed that homeless women with serious mental illness are not receiving care, perhaps due to the lack of perception of the extent of mental health problems and the lack of services designed to meet mental health needs.⁸ Bogard et. al (1999) critique recent service-intensive shelter programs for homeless mothers. This study showed that mental health services had little impact on depression levels and that isolation from social networks is what increased depression levels among homeless mothers. The authors suggest putting less emphasis on providing services and more emphasis on integration into the community by providing housing.²⁸ However, this does not address a woman's ability to remain housed and the events that led up to her homelessness in the first place. Women with serious mental illness, such as schizophrenia, may be unable to function independently without adequate treatment. Those that experience depression may be encountering other hardships that would not allow them to fully integrate into society or a new housing situation.

The Role of State Title V Programs

There are several roles State Title V programs can play to assure the health of homeless women of reproductive age. States can assist in collecting the necessary data and relevant information in order to form better policies and provide better health care. Research studies tend to focus on women they can find: homeless women in shelters. This ignores the women who are at-risk of becoming homeless (those women who are living doubled-up with friends and relatives, low-income women with inadequate support networks), and the street homeless (those women living in their cars, in parks, under bridges, etc.). State Title V Programs should work with their state's office of homeless services and health care for the homeless program (in those states that have them) to determine ways to reach out to homeless women both in and outside of shelters. Also, surveys need to distinguish between women who are mothers with children, as opposed to solitary women, since health care service delivery implications will differ.

State Title V programs can assist other relevant federal and state programs (e.g., community health centers) with the charge of providing services to homeless women, especially through existing referral and networking opportunities. Although one study's findings raised concerns that specialized services for homeless persons, and/or the stigma of a person's being homeless, may disrupt ties to private physicians or health maintenance organizations, it also states that institutional providers (e.g., community health centers and public clinics), which generally have more commitment to serving homeless and other vulnerable populations, may be better suited to meet the needs of the homeless or formerly

homeless families.²⁹ Strategies around use of mobile medical units and other mobile forms of health outreach that bring health care services to the women (and their families) at more flexible hours could help overcome barriers such as transportation and clinic schedules.^{30,31}

State MCH programs have access to clinics and specialized knowledge about how to reach women in general, and specifically underserved, low-income women. This knowledge can be applied in several ways. As managed care has become more prominent in the states' Medicaid programs, State MCH programs can work to promote (to the greatest extent possible) the implementation of recommendations such as:

- ❖ including identification of homeless Medicaid beneficiaries in the outreach and education phase;
- ❖ using housing status or homelessness as markers for increased health risk; and,
- ❖ development of specific quality assurance activities and outcome measures focusing on homeless enrollees, in collaboration with advocates and experienced homeless service providers.³²

In working with their state's Medicaid office, MCH program staff can encourage provider-screening of women about their housing situation in order to determine if their patients are at-risk for homelessness, and in need of additional social services, or are homeless, and thus also in need for a specialized prevention or therapeutic plan of care. To do this, Title V programs might assist with screening tools, referral resources, and training. Health care providers and others who interact with the homeless could assist more women by doing assessments and referrals in settings homeless women frequent with their children (immunization clinics, schools, child care, pediatricians' offices, etc.). Title V programs can improve referrals to domestic violence programs (as available), which then could lead to referral to additional supportive services.

Other issues around which State Title V programs could be advocates include promoting the use of portable health insurance to facilitate eligibility for and access to services, and addressing the special needs of mentally ill women who are homeless. State Title V programs also can advocate for more available inexpensive housing for the low-income population. One recommendation that has been made is for shared housing facilities where women are provided a private room and access to shared space for meals, laundry, and socialization. Social and other wrap-around services can be located there as well.

If State Title V programs are not doing so already, they should participate in the development of the state's or community's *Consolidated Plan* for HUD, providing their expertise, and facilitating citizen input where available. The Title V program also could participate on the state's Interagency Council and/or Task Force on Homelessness (in those areas that have them). Keeping homeless women's issues on the Title V program's agenda should lead to improved coordination and provision of health care for these

most vulnerable of women.

Given the broad definition of “health,” it is important to recognize that homeless women *inherently cannot be healthy*. Until these women find housing, a stable source of income, and food on a regular basis, etc., they will not be able to benefit fully from the health care services that Title V programs are attempting to ensure.

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